

Case reports of interprofessional care for clients enrolled in a mental health court

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How to cite: DeJongh B, Oldani M. Case reports of interprofessional care for clients enrolled in a mental health court. Ment Health Clin [Internet]. 2018;8(6):317-21. DOI: 10.9740/mhc.2018.11.317.

Abstract

Background: An interprofessional mental health court (MHC) team was created in Milwaukee, Wisconsin, in 2014 to help keep low-level offenders with mental health (MH) disorders out of the correctional system. The focus of MHC is on stabilization of MH disorders and rehabilitation rather than incarceration. A clinical MH pharmacist was added to the team in 2015 to provide expertise on psychotropic medication regimens and to meet with clients for medication education.

Case Reports: A 58-year-old black male was admitted to the MHC after he failed to provide sex registry information. His past medical history was significant for major depressive disorder, schizophrenia, substance use disorders, and seizures. At the time of pharmacy review, medications included aspirin, levetiracetam, risperidone, ziprasidone, and paroxetine. The pharmacist identified 3 potential drug therapy problems (duplicate therapy, potential adverse drug reaction, and inadequate dosage) and sent a letter to his psychiatrist. Risperidone and ziprasidone were switched to aripiprazole, and he was referred to a neurologist. He was eventually terminated from the MHC because of multiple violations. A 34-year-old black male was admitted to the MHC for disorderly conduct and destruction of property. His past MH history was significant for schizophrenia and substance use disorders. He was not taking psychiatric medication upon admission to MHC. While the client was institutionalized for competency determination, collaboration between the MHC pharmacist and psychiatrist resulted in the prescribing of a long-acting injectable antipsychotic, which the client was stabilized on. He subsequently graduated from the MHC.

Discussion: Clinical MH pharmacists play a key role on MHC teams by providing medication education, identifying drug therapy problems, and communicating with the clients' medical providers. Lack of access to medical records, court schedule conflicts, and collaboration between interprofessional groups that historically have not worked together are challenges to a pharmacist working on an MHC team.

Keywords: mental health court, interprofessional, mental health clinical pharmacist

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Disclosures: There are no actual or potential conflicts of interest by any authors of this paper.

Background

Similar to drug treatment courts (DTC), mental health courts (MHC) have increased in the United States with the central mission to divert individuals with mental illness (MI) away from long-term incarceration or jail time and into treatment.¹ The main difference between DTCs and MHCs centers on the client's type of criminal activity. The DTC admission is based on a client's drug-related offense

(eg, possession of heroin or cocaine), with or without MI. Whereas within an MHC, the offender has been diagnosed with MI and has committed a non-drug-related offense (eg, disorderly conduct or robbery). The MHC participants often have substance use disorders secondary to their MI. There may also be differences in treatment plans, advocacy, ability to work, monitoring, and service delivery (eg, case management, social work, housing) between DTCs and MHCs.² The MHC movement is a response to the increasing numbers of incarcerated individuals with MI in the United States and globally.^{3,4}

Milwaukee created its first MHC in 2014 through a collaboration between the district attorney, chief judge, and the office of the public defender. An interprofessional team was established that included the judge, assistant district attorney, assistant public defender, case managers, probation officers, community-based police officers, county housing representative, peer support specialist, psychiatrist, and medical anthropologists. A pharmacist was added to the team during the fall of 2015. The court oversees a case load of 5 clients and is run pro bono because there is no sustainable funding source. Thus far, 17 clients (15 men and 2 women) have participated in the Milwaukee MHC, and the rate of successful program completion is 56%. The average time in the program for clients with successful completion is approximately 13 months.⁵

Clients can be referred to the MHC if they have committed a misdemeanor or non-violent felony, have 1 or more diagnosed mental health (MH) disorder(s), and have not been charged with a felony drug offense. The judge, assistant district attorney, and assistant public defender assigned to the court consult to select candidates for the program based on high use of both the criminal justice system and MH services. The candidates are then presented to the MHC team, and members reach a consensus regarding who should be allowed to participate. The process for selecting clients is more subjective and intuitive rather than objective. The MHC is held 2 times per month, and clients are seen at 2-week or 4-week intervals, depending on their progress and/or setbacks, which can include failed drug tests and missing appointments with probation officers or others coordinating their care (eg, psychologists, physicians, and case managers). In general, the court works to move clients through 3 phases: (1) Stabilization (build trust with the team and ensure mental/medical health adherence); (2) Skill Building (through programming, education, job preparation, and treatment referrals); and (3) Permanence (identify triggers, prevent relapse, and develop wellness recovery action plan). Ideally, clients work with case managers toward full independence and long-term care plans upon their release from the court, which also represents the end of their probation period.

Team meetings are held prior to court to provide interprofessional direction and assessment of client progress. During the first year of the MHC, the team used meeting time to discuss and critique the court, make recommendations for changes, and bring in guest speakers to help educate the team on related topics. Medical anthropologists studying and assessing the court team made recommendations to foster client-centered care. In particular, they recommended adding a pharmacist to the team.⁵ The complexity of psychiatric medications being administered to clients, as well as clients' ability to self-medicate with other substances, required more expertise on drug-drug interactions, adverse effects, and efficacy as it relates to specific MH diagnoses. During early 2016, the MH pharmacist on the team began meeting with clients who were in need of medication counseling prior to court. The following cases illustrate the role of the pharmacist in the MHC.

Case Report 1

A 58-year-old black male with a past medical history significant for major depressive disorder, schizophrenia, substance use disorders (alcohol and cocaine), and seizures was accepted as a client to the Milwaukee MHC on December 1, 2015 after he was arrested for failure to provide sex registry information. His prior criminal history included a sex offense in the 1990s, which put him on the Wisconsin sex offender registry. Medications on admission included aspirin 81 mg by mouth daily, levetiracetam 500 mg by mouth daily, risperidone 2 mg by mouth daily, ziprasidone 20 mg by mouth daily, amitriptyline 100 mg by mouth daily, and trazodone 50 mg by mouth every night at bedtime. He was later switched from amitriptyline to paroxetine 20 mg daily because of ongoing depressive symptoms. Medical records were not available to the court so information on past medical history and his medication regimen were provided by his case manager. The client consistently endorsed symptoms of depression when speaking to his attorney and described his mood as "up and down." In August 2016, the pharmacist wrote a letter to the client's psychiatrist to inform him of concerns regarding his mood. The pharmacist outlined the following potential drug therapy problems and recommendations: (1) Duplicate Therapy – The client is taking 2 low dose antipsychotics. Consider optimizing the dose of either the risperidone or ziprasidone, while discontinuing the other, to help reduce pill burden and potential for additive adverse effects; (2) Potential Adverse Effects – Levetiracetam is associated with psychiatric adverse effects. Client endorses symptoms of depression, but it is unclear to the court if levetiracetam is contributing. Consider referral to neurology for further evaluation of his seizure diagnosis and treatment regimen if he has not been evaluated in the

recent past; and (3) Inadequate Dosage – Client continues to endorse feelings of depression. Consider increasing the dose of paroxetine.

The client met with his psychiatrist in September 2016 and was switched from risperidone and ziprasidone to aripiprazole 10 mg by mouth daily to target symptoms of psychosis and depression while reducing polypharmacy. No additional medication changes were made while this client participated in the MHC. He was scheduled to see a neurologist but did not attend the appointment. The client was eventually terminated from the MHC because of continued drug use and failure to report to his case manager/probation officer or his medical/court appointments.

Case Report 2

A 35-year-old black male with a past medical history significant for schizophrenia, substance use disorders (alcohol and marijuana), chronic back pain, and multiple sclerosis was accepted as a client to the Milwaukee MHC on March 9, 2017. He was arrested for disorderly conduct and criminal damage to property after he broke a police station window. He was unemployed and homeless for weeks at a time when not staying in public shelters. He was not taking any medications on admission to the MHC but was prescribed antidepressants and antipsychotics in the past. The MHC did not have access to his medical records. Per county case managers, his major issue was non-adherence with oral medications. He did not commit criminal activities when he was adherent with psychiatric medications. However, when non-adherent with medications, he engaged in criminal activity and missed appointments with case managers, psychiatrists, and probation officers. The pharmacist and psychiatrist on the team advocated strongly for use of a long-acting injectable antipsychotic. Education was provided to the client on the potential benefits of long-acting injectable formulations of medications. His case manager was able to secure a bed at a state-run MH hospital, where he was admitted for treatment and to reestablish competency. The treating psychiatrists agreed with initiation of a long-acting injectable antipsychotic, but it was unclear to the MHC team how the final medication regimen was selected. He was eventually stabilized on fluphenazine decanoate 25 mg intramuscularly every 2 weeks and gabapentin 300 mg 3 times daily. He fully participated in the MHC after discharge from the hospital and the remainder of his urine drug screens were negative for marijuana. He moved into county-sponsored housing and attended all appointments. He successfully completed probation and graduated from the MHC on May 25, 2018.

Discussion

Although there are reports of pharmacists participating on advisory boards for MHCs,⁶ as well as requirements for MHC participants to seek consultation with a pharmacist,⁷ there are no other published reports on the integration of pharmacists within a coordinated, interprofessional MHC team that the authors are aware of. These cases illustrate the role clinical MH pharmacists can play on interprofessional MHC teams based on their knowledge of psychotropic medications. The client in case 1 was not able to successfully complete the MHC program, but he stabilized on medications, found more stable housing, completed probation, and has not reoffended as of July 2018. His case was selected because it is representative of the types of commonly encountered drug therapy problems in the Milwaukee MHC. In addition, the pharmacist's letter prompted reevaluation of the medication regimen and ultimately reduced polypharmacy even though the psychiatrist did not exactly follow the pharmacist's recommendations. Case 2 illustrates how relatively simple recommendations can have a large impact and help clients succeed in MHC programs. This case also shows how members of the MHC team collaborate interprofessionally to provide comprehensive care with treatment, housing, etc. Both cases highlight how pharmacists can intervene and participate in the care of clients in these programs.

Medication questions often arise while discussing the clients during meetings, and MH pharmacists can provide education, correct misconceptions, and identify potential drug therapy problems. Mental health pharmacists can also meet with clients of the court to answer medication related questions, address concerns, provide additional education, and help with adherence-related issues. Many of the Milwaukee MHC clients benefit from long-acting injectable medications to help with adherence, and the MH pharmacist plays a key role in identifying medications that can be switched to a long-acting form. The MH pharmacist can also help address polypharmacy through recommendations for deprescribing. Deprescribing is an emerging practice in which health care providers work to optimize the medication regimen by reducing unnecessary or redundant medications.⁸ Concerns about substance use and other related disorders also arise. Mental health pharmacists possess the knowledge to provide education on such things as good sleep hygiene, smoking cessation, and the dangers associated with using illicit substances.

There are several potential challenges for MH pharmacists to overcome when working on an interdisciplinary MHC team. The MHC participants can sign consent for the sharing of medical records. However, there often remains limited access to medical records because of the logistical challenges of multiple providers, health systems, insur-

ance plans, and both paper and electronic records. Currently, the majority of the information on the client's past medical history and medications comes from the case manager, probation officer, or public defender. Therefore, it can be difficult to make medication recommendations. Without reliable medical records, the MH pharmacist often has to speculate on how or why clients are taking a certain medication regimen. To date, no providers of MHC clients felt compelled to participate in MHC meetings. Legally, the court cannot compel a provider or pharmacist to participate.

The role of the psychiatrist on the team evolved from consultative to active participation in the recommendations for care of clients. More recently, a county MH complex psychiatrist replaced the original psychiatrist on the team and began advising on diagnoses, medications, and the logistics of local MH care. In the future, if an MHC participant were under the care of a provider contracted through county services, the county could compel that provider to attend meetings prior to court. More typically, the MH pharmacist writes a letter to the client's psychiatric provider outlining potential drug therapy problems and medication recommendations based on limited information and discussions with clients prior to court. This was the first process developed by the pharmacist but has shown to be circuitous with minor changes made to medication regimens. Without the provider present, there is occasional resistance from case managers to take on the additional work of navigating client appointments. There are no formal collaborative agreements between the MHC and local providers of psychiatric care. However, the MH pharmacist and new psychiatrist on the team are beginning to collaborate on medication recommendations and ways to directly communicate with community psychiatrists.

Another interprofessional challenge is trying to coordinate schedules in a way that works for all team members. A set schedule was put in place but often changed because of alterations in the judge's calendar. These schedule changes make it difficult for the MH pharmacist to consistently attend because of other work-related responsibilities. None of the team members receive extra compensation for their work related to this particular MHC, and the pharmacist volunteered the time as a service to the community. This can make it difficult to advocate for additional time off of regularly scheduled work responsibilities.

Finally, there can be challenges related to collaboration between nontraditional, interprofessional partners that historically have not worked together.⁹ Pharmacists are not typically in a position where they are working with lawyers, judges, and probation officers. There is a steep learning curve when it comes to the legal terminology and

available services. Different psychiatrists have participated on the team. Collaboration between the psychiatrist and the MH pharmacist varied without clearly defined roles and a coherent plan on medication management for court enrollees. The role and value of the MH pharmacist on the team became unclear when there was less collaboration.

Suggestions to overcome the challenges that pharmacists face as participants in an MHC include clearly defining and modeling the role of the MHC pharmacist after that of the DTC pharmacist,¹⁰ using a standardized form to obtain release of information from the clients' provider(s), encouraging participation of the clients' psychiatric provider(s) in MHC team meetings, establishing a set schedule for MHC meetings, involving pharmacy students and residents in the MHC process, and securing outside funding to financially support the role of the pharmacist.

Conclusion

Pharmacists continue to expand their roles within community MH care.¹¹ The MH clinical pharmacists could play an important role on MHC teams by providing medication education, identifying potential drug therapy problems, assisting with medication adherence, and discussing the dangers associated with illicit substance use. Pharmacists can assist clients in successfully completing the MHC program by ensuring their MH symptoms are adequately treated while considering the tolerability and safety of their medication regimens. Lack of access to medical records, court schedule conflicts, and collaboration between interprofessional groups that historically have not worked together are potential challenges to working on an MHC team. These challenges can be overcome through more robust collaboration that focuses on consistent access to medical/hospital records, direct communication with clients' psychiatric provider(s), establishing a synchronized calendar for all team members, securing permanent funding solutions, and creating more opportunity for shared decision making during, and outside of, regular court meetings.

References

1. Castellano U, Anderson L. Mental health courts in America. *Am Behav Sci*. 2013;57(2):163-73. DOI: [10.1177/0002764212465616](https://doi.org/10.1177/0002764212465616).
2. Bureau of Justice Assistance [Internet]. New York: Council of State Governments Justice Center; c2008 [updated 2009 Jun 18; cited 2018 Sep 14]. Mental health courts: a primer for policymakers and practitioners. Available from: https://www.bja.gov/Publications/MHC_Primer.pdf
3. James DJ, Glaze LE [Internet]. Washington: US Department of Justice Office of Justice Programs; c2006 [updated 2006 Dec 14; cited 2018 Jun 7]. Mental health problems of prison and jail inmates. Available from: <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>

4. Fazel S, Hayes AJ, Bartellas K, Clerici M, Trestman R. Mental health of prisoners: prevalence, adverse outcomes, and interventions. *Lancet Psychiatry*. 2016;3(9):871-81. DOI: [10.1016/S2215-0366\(16\)30142-0](https://doi.org/10.1016/S2215-0366(16)30142-0). PubMed PMID: 27426440.
5. Brodwin P, Oldani M, Tsao C. Process evaluation: mental health court pilot program. Executive Summary. Milwaukee: Concordia University Wisconsin, Office of Interprofessional Education; 2017 Apr.
6. Callahan L, Steadman HJ, Gerus L [Internet]. Delmar (NY): Policy Research Associates; c2013 [updated 2013; cited 2018 Sep 14]. Seven common characteristics of juvenile mental health courts. Available from: http://ndcrc.org/sites/default/files/common_characteristics_508_o.pdf
7. Yakima County [Internet]. Yakima (WA): Yakima County; c2015 [updated 2015 Apr 7; cited 2018 Jun 7]. Yakima County mental health court: participant handbook. Accessed from: <https://www.yakimacounty.us/DocumentCenter/View/8572/MHC-Handbook-04-07-15>
8. Gupta S, Cahill JD. A prescription for “deprescribing” in psychiatry. *Psychiatr Serv*. 2016;67(8):904-7. DOI: [10.1176/appi.ps.201500359](https://doi.org/10.1176/appi.ps.201500359). PubMed PMID: 26975524.
9. Cuff (Rapporteur) PA, editor. Interprofessional education for collaboration: learning how to improve health from interprofessional models across the continuum of education and practice: workshop summary; 2013 Oct. 3; Washington: The National Academies Press; 2013.
10. Palombi LC, Koh-Knox CP. The drug court pharmacist: expanding pharmacy practice and addressing substance abuse. *Inov Pharm*. 2016;7(3):Article 12. DOI: [10.24926/iip.v7i3.455](https://doi.org/10.24926/iip.v7i3.455).
11. Rubio-Valera M, Chen TF, O'Reilly CL. New roles for pharmacists in community mental health care: a narrative review. *Int J Environ Res Public Health*. 2014;11(10):10967-90. DOI: [10.3390/ijerph111010967](https://doi.org/10.3390/ijerph111010967). PubMed PMID: 25337943.